

# Psychological Services

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# Psychologists With Lived Experience of Non-Suicidal Self-Injury: Priorities, Obstacles, and Recommendations for Inclusion

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The science and practice of psychology are improved by fostering an inclusive environment for professionals with lived experience of mental illness, sometimes referred to as “prosumers”. Non-suicidal self-injury (NSSI) is an increasingly prevalent behavior that occurs across the spectra of mental disorders, and that is associated with greater stigma than many other mental health concerns. Further, individuals with lived experience of NSSI may face unique challenges, for instance, due to the visible nature of NSSI scarring. In this commentary, we describe the negative consequences associated with stigmatizing and excluding people with lived experience of NSSI from the profession of psychology, both for impacted individuals and for the field as a whole. We then provide recommendations to individuals *with* and *without* lived experience of NSSI to facilitate inclusion of people with lived experience of NSSI in clinical, research, teaching, and leadership domains.

*Keywords:* lived experience, prosumer, non-suicidal self-injury, stigma, clinical psychology

In 2009, the first author applied to clinical psychology doctoral programs with mentors investigating non-suicidal self-injury (NSSI), the deliberate, direct damage to bodily tissue without suicidal intent (International Society for the Study of Self-Injury, 2018). During a phone interview, a tenured clinical faculty member asked, “So, self-injury? *Why* would you want to study *that*?” Following a thoughtful, professional answer about the need to study this poorly understood, yet highly prevalent, behavior, the faculty member scoffed, “*Well*, now I wish we were doing this interview in person, so I could surreptitiously look at your wrists.”

This experience, though discouraging, was certainly not an isolated incident. Some professionals in the field comment disparagingly toward individuals who treat or study a mental health problem with which they have struggled, sometimes glibly referred to as “me-search” (Sumerau, 2015). Graduate school applicants are often advised to exclude details about personal mental health experiences, including NSSI, in their applications, lest these be viewed as a “kiss of death” (Appleby & Appleby, 2006, p. 19). Given the extremely competitive nature of graduate programs in clinical psychology (Norcross et al., 2018), applicants may reasonably choose to omit information about personal experiences, such as NSSI, from their materials, as disclosure could impact their likelihood of acceptance. This fear of stigma and its negative consequences seem justified, given data from a national survey of training directors of accredited

American doctoral programs and predoctoral internships (Huprich & Rudd, 2004). Here, researchers found that roughly three-quarters of programs consider applicants’ “psychological suitability” as part of their admissions procedures, and over one-quarter of respondents indicated that acknowledgement of *past* (not current) psychological impairment might preclude that student’s admission into the program (Huprich & Rudd, 2004, p. 47). There are also data from the broader domain of student mental health to suggest that disclosure in educational settings can have negative consequences. In a large Australian survey, people who told instructors about a mental health diagnosis were more likely to report discrimination related to their mental health; this was not the case for disclosures in the workplace, or to friends or family (Reavley et al., 2018). It is unclear, however, whether disclosures themselves *lead* to greater discrimination, or vice versa, as well as the nature of the types of discrimination experienced in these settings. Far from being limited to the early years of professional training, implicit and explicit biases impact professionals throughout their careers. For instance, many state regulatory boards require applicants for licensure as a clinical psychologist to disclose historical mental health information, regardless of whether there is any current evidence of professional impairment (Boyd, Graunke, et al., 2016).

Unfortunately, there is limited empirical research characterizing the nature and consequences of inclusion of psychologists who have experienced mental illness in the field, and no known research specific to experiences of NSSI among psychologists. What limited work exists often focuses on issues of professional impairment (e.g., Huprich & Rudd, 2004; Sherman, 1996), rather than on past experiences of psychological difficulties as they may or may not impact one’s professional experiences. This is unfortunate, given the high rates of reported personal psychotherapy and clinical symptoms (including depression and suicidality) among psychologists. For instance, in a large survey of psychologists, over 80% reported having received psychotherapy at some point, and almost 30%

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reported having felt suicidal at some point during therapy (Pope & Tabachnick, 1994). In a more recent study of counselling psychologists, over 60% reported experiencing depression during their time providing clinical services, and 42% of those who sought treatment for mental health concerns reported some experience of suicidal thoughts or behavior (Gilroy et al., 2002). Further research is needed to clarify the extent to which psychologists have lived experience of NSSI, and how these experiences might impact professional practice in research and clinical domains.

### Why Focus on Inclusion?

In this commentary, we argue that inclusion within psychology of people with lived experience of mental illness yields significant benefits both to those with lived experience and to the field at large. First, recent work demonstrates that mental health professionals with lived experience of a variety of mental health concerns are often very successful in their professional endeavors (Boyd, Zeiss, et al., 2016). In clinical settings, providers with lived experience of mental illness endorse fewer stigmatizing views of clients and exhibit no greater professional impairment compared to colleagues without lived experience (Harris et al., 2016). People with lived experience of mental illness can also contribute to improved relevance and quality of psychological research (Banfield et al., 2018; Lewis & Hasking, 2019). In fact, Canada's largest funding agency, the Canadian Institutes of Health Research (CIHR), now prioritizes support of research that includes direct involvement of people with lived experience as active agents in the research—that is, *as* researchers (Canadian Institutes of Health Research [CIHR], 2018).

Second, stigma and other barriers likely contribute to both *exclusion* of individuals with lived experience of mental illness from the field entirely, as well as to *silencing* of people with lived experience within the field. The former is, on its face, inconsistent with psychologists' stated values of justice and respect for people's rights and dignity (American Psychological Association [APA], 2017). The latter is associated with a host of negative consequences for individuals and their professional work. Emotionally, feeling pressured to keep one's lived experience secret is associated with impaired help-seeking, substance misuse, and other negative psychological consequences (Cepedo-Benito & Short, 1998; Pachankis, 2007; Talley & Littlefield, 2014). Professionally, discomfort disclosing one's own experiences may impair one's ability to receive effective mentoring around integrating lived experience into a professional identity (Zerubavel & Wright, 2012).

### Why Focus on NSSI?

Although the above implications apply to a variety of mental health concerns, there are several reasons to focus on lived experience of NSSI specifically. First, NSSI is a transdiagnostic behavior that co-occurs with numerous emotional disorders, including depressive disorders, generalized anxiety disorder, panic disorder, and post-traumatic stress disorder (Bentley et al., 2015), and recent evidence suggests that the prevalence of NSSI has increased over the past decade, with lifetime rates among entering college freshman jumping from 16% to 45% from 2008 to 2015 (Wester et al., 2018). Although specific prevalence rates of NSSI among psychologists have not been documented, there is no reason to expect NSSI to be any less prevalent than other mental health concerns, which are

common among psychologists (see Gilroy et al., 2002; Pope & Tabachnick, 1994). Second, NSSI is unique amongst psychological difficulties, which are typically considered concealable stigmatized identities (Bos et al., 2009), in that scarring is common, making an otherwise invisible identity apparent (Lewis, 2016a; Lewis & Mehrabkhani, 2016). Third, research suggests that NSSI is associated with greater shame and stigma than other mental health concerns (Hasking & Boyes, 2018), which may be due to erroneous views of NSSI as an attempt to manipulate others (Lloyd et al., 2018), even among medical professionals (Gibb et al., 2010; McAllister et al., 2002). These beliefs may, implicitly or explicitly, lead to viewing people with lived experience of NSSI as unsuitable for psychological practice or as undesirable lab members, trainees, or colleagues. Academic communities are not exempt from these biases; in several recent high-profile cases, universities have been accused of mishandling their responses to students engaging in NSSI, leading to involuntary leaves, disciplinary actions, and even expulsion of impacted students (Baker, 2014; Hartocollis, 2018; Irvin-Mitchell, 2017; Williams, 2014). Fourth, there has been a recent call for greater inclusion of people with lived experience in NSSI research, including as researchers (Lewis & Hasking, 2019). Accordingly, consideration of the role that individuals with lived experience of NSSI can play in the broader field of clinical psychology is not just timely, but also essential. Finally, there are very few psychologists who have publicly disclosed their experiences with NSSI (with the notable exceptions of Dr Marsha Linehan and Dr Stephen Lewis; Carey, 2011; Lewis, 2016b), and consequently few role models for those who may wish to be more public about their lived experience of NSSI.

### Recommendations

In an attempt to address a variety of factors relevant to inclusion of individuals with lived experience of NSSI, we offer a series of recommendations meant to guide those with and without lived experience as they navigate these issues (see Figure 1). These recommendations draw upon the limited published literature in these domains, as well as the personal and professional experiences of the authors. It is important to note that there has been almost no empirical work that specifically focuses on lived experience of NSSI among mental health professionals. Thus, we hope that this commentary will not only facilitate greater inclusion of people with lived experience of NSSI in the field, but also spark greater research in this domain to improve subsequent recommendations in this area. Although some recommendations are specific to NSSI, many may apply equally to other aspects of mental illness. These recommendations are likely to be most relevant to North American clinical psychology settings, and may need to be adapted for other countries, cultures, and fields of study. In each section, recommendations that apply to all psychologists, regardless of lived experience of NSSI, appear first, as many recommendations are consistent for individuals with or without lived experience of NSSI. Then, later in each section, we provide specific recommendations for those with and without lived experience separately. We have chosen this structure, rather than division on the basis of professional roles (e.g., clinician, supervisor, mentor, and student), given the overlap between these roles across psychologists' professional lives, and the inclusion of individuals with and without lived experience of NSSI in each of these domains.

**Figure 1***Recommendations to Facilitate Inclusion of Psychologists With Lived Experience of NSSI***1. Recognize Personal Biases**Recommendations for people with lived experience

- Engage in reflection to identify how values and experiences can contribute to biases.
- Avoid making assumptions about the generalizability of one's personal experiences.
- Avoid over-identification with clients or research hypotheses.
- Seek consultation to address potential negative influences of countertransference.

Recommendations for people without lived experience

- Engage in reflection to identify how values and experiences can contribute to biases.
- Seek out continuing education regarding NSSI.

**2. Prepare to Learn of Others' Lived Experience of NSSI**

- Consider and prepare for responding to both intentional and inadvertent disclosures of lived experience of NSSI.
- Respond in a nonjudgmental, empathetic, respectful manner.
- Focus on the needs and goals of the person disclosing.
- Do not share someone else's lived experience of NSSI without explicit permission.

**3. Prepare to Be Asked about Personal Experience of NSSI**Recommendations for people with lived experience

- Consider preparing specific responses for different contexts.
- Recognize personal limits; only disclose information needed to achieve one's goals.

Recommendations for people without lived experience

- Consider how one's response may impact others' assumptions about NSSI.

**4. Prepare to Address Relevant Professional or Personal Concerns**

- Avoid the assumption that *past* NSSI necessarily indicates a *current* need for help.
- Be aware of local resources and supports for individuals seeking assistance.
- If concerns prompt the need to disclose someone's NSSI to another person, be transparent regarding this decision and engage in consultation as needed.

**5. Model Openness to Inclusion of People with Lived Experience of NSSI**

- Foster open dialogue on the role of lived experience in clinical, research, and teaching.
- Avoid language that separates those with mental illness from psychology professionals.
- Advocate to include lived experience of mental illness in diversity-focused efforts, e.g.:
  - Diversity, equity, and inclusion statements
  - Mentoring programs for underrepresented scholars
  - Allyship or "Safe Zone" programs (c.f., Human Rights Campaign, 2019)
- Advocate for regulatory and/or statutory changes that impact psychologists with lived experience of mental illness (e.g. inquiries regarding past psychological difficulties as part of the psychology licensure process; Boyd, Graunke et al., 2016).
- Support the appointment or election of individuals with lived experience to leadership positions in research and clinical domains.

**Recommendation 1: Recognize Personal Biases**

A common concern raised about psychologists with lived experience of mental illness is lack of objectivity. Rather than trying to distinguish groups as inherently more or less objective, it is more accurate to recognize that objectivity itself is a flawed notion; *all* individuals from *all* disciplines bring their own subjective humanity, experiences, and perspectives to their work (Grollman, 2014). Awareness alongside careful evaluation and monitoring of personal biases

are hallmark steps to ensuring multicultural competence (Sue et al., 2019), and similar processes are likely important to address implicit biases in other professional domains. The need to identify and remediate implicit and explicit biases is especially important in evaluative settings, such as research grant review panels, admissions and hiring committees, and journal editorial boards. More research is needed to determine the most effective ways to address biases relevant to mental health concerns, including NSSI, among psychologists.

### ***Recommendations for People With Lived Experience***

People with lived experience are viewed as preferred treatment providers in some spheres, such as substance abuse counseling (Culbreth, 2000). Some argue that personal experience of mental illness improves one's ability to empathize with clients, for instance, by exhibiting patience regarding the pace of therapeutic improvement (Gelso & Hayes, 2007; White, 2000). In research, people with lived experience of NSSI may contribute unique insights that can inform research hypotheses, study design, and data collection methods (Jones et al., 2014; Lewis & Hasking, 2019).

There is danger, however, in assuming one's own NSSI experience is representative of others. It is essential to avoid over-identification with clients or research hypotheses to ensure that personal experience does not bias data interpretation or treatment decisions (Gelso & Hayes, 2007). In addition to those recommendations noted above (e.g., self-awareness and reflective assessment of biases), we also encourage consultation with trusted colleagues to address any negative influences of countertransference due to lived experience (Smith & Moss, 2009).

### ***Recommendations for People Without Lived Experience***

The significant stigma surrounding NSSI is often associated with inaccurate beliefs about these behaviors (Lewis et al., 2014). Thus, it is important to consider how one's own values, prior experiences, and knowledge may impact interactions with individuals who have engaged in NSSI. We recommend that psychologists seek out continuing education on NSSI, both to improve one's own knowledge of this prevalent behavior, as well as to develop increased competency to effectively discuss and address NSSI in non-judgmental, empathetic ways.

### **Recommendation 2: Prepare to Learn of Others' Lived Experience of NSSI**

Effective responses to disclosure of NSSI will differ based on the relationship that exists between the recipient and the person making the disclosure (e.g., trainee, supervisor, and colleague). Responses that reflect a non-judgmental, empathic, respectful stance toward learning of the lived experience are likely to be most effective and well received (Klonsky et al., 2011; Walsh, 2012). In this context, it is important to focus on the needs and values of the person disclosing their lived experience, rather than on satisfying the recipient's curiosity about the nature of NSSI (e.g., methods and functions) or its perceived cause (e.g., history of trauma and diagnosed mental illness). Instead, we recommend respectfully assessing the level of support the person may (or may not) need or want, while respecting the privacy of the person disclosing. As with disclosure of any potentially stigmatized identity, we strongly advise against sharing information about someone's lived experience of NSSI without their permission.

In order to provide appropriate and effective responses to an NSSI disclosure, it may be helpful to prepare what to say or do in advance. This is particularly important given that early negative experiences with NSSI disclosure may contribute to greater self-stigma and shame (Rosenrot & Lewis, 2020). In clinical training contexts, negative self-disclosure experiences appear to weaken supervisory relationships and decrease the odds of later self-disclosures (Gray et al., 2001).

These experiences can have a subsequent negative impact on clinical care, insofar as supervisees may be receiving ineffective or incomplete supervision.

Due to scarring and/or injuries produced from NSSI, it is possible to learn about someone else's NSSI without a direct, verbal disclosure (Lewis & Hasking, 2019; Rosenrot & Lewis, 2020). It is important to respect the privacy of the person with lived experience and realize they may not be interested in disclosing at that specific time (or ever). Consequently, we strongly oppose asking intrusive questions about an individual's scars or injuries, especially if there are no concerns about their well-being or professional competence. If there *are* such concerns, however, and it becomes necessary to explicitly ask about a person's NSSI history, we recommend addressing the issue from an empathetic, respectful, and non-judgmental stance. Should the person deny a history of NSSI, respect their right to privacy, acknowledging that individuals may feel differently about "coming out" regarding their lived experiences in different contexts and at different times throughout their lives. It can be helpful to convey a non-judgmental stance and openness to a future disclosure, if relevant. Although some research has addressed the consequences of physical scarring related to NSSI, as well as its implications for NSSI disclosure (see above), more work is needed to understand how these experiences are best addressed in clinical and related professional contexts.

### **Recommendation 3: Prepare to Be Asked About Personal Experience of NSSI**

As highlighted in the opening paragraph of this commentary, psychologists and trainees may field inquiries regarding NSSI, regardless of one's *actual* lived experience. This can occur following someone else's disclosure of NSSI, or in a clinical context involving NSSI. In Dr Marsha Linehan's account of her own experience with NSSI, she described patients who asked about her own visible scarring, to which she reportedly responded, "You mean, have I suffered?" (Carey, 2011). The choice of how to respond is necessarily informed by one's lived experience, theoretical orientation, type of treatment being provided, clients' presenting problem(s), and the relative risks and benefits of disclosure for clients or patients. Research that characterizes clients' views regarding clinicians' lived experience of mental illness, including NSSI, would be valuable in establishing clearer recommendations in this domain.

### ***Recommendations for People With Lived Experience***

Given the potentially invasive nature of questions about lived experience of mental health concerns, one option is to simply decline to discuss these experiences with others. If disclosing one's personal history of NSSI, we recommend knowing one's own limits and providing only the information that feels necessary to achieve one's goals. Some people may prefer having a prepared statement to respond to specific questions they do not wish to answer, such as, "I'm not sure it's necessary for you to know all this to support me," or, "I'm not comfortable sharing more of these details at this time; thank you for respecting my privacy." These responses may also vary depending on the person asking (peer, supervisor, mentor, and client), the environment in which the conversation is occurring, and one's current feelings around one's NSSI history.

### **Recommendations for People Without Lived Experience**

Although this issue may seem straightforward, one's response to these questions can have a significant impact on how others feel about their own lived experience (if relevant) and/or how observers themselves may respond to such questions in the future. For instance, a response like, "Me? Of course not!" implies that psychologists can't (or shouldn't) have experiences with NSSI. For guidance regarding what types of questions to ask (or to avoid asking) of individuals with lived experience of NSSI, please see our recommendations regarding responses to others' disclosures related to NSSI (Recommendation 2) and regarding assessment of professional or personal concerns related to NSSI (Recommendation 4).

### **Recommendation 4: Prepare to Address Relevant Professional or Personal Concerns**

Some clinical psychologists act as professional gatekeepers who are tasked with evaluating individuals' suitability to provide psychological services. Although having previously engaged in NSSI does not necessarily imply a current need for additional support or supervision, there may be times when a professional with lived experience of NSSI, just like any other psychologist, may need additional support for their psychological well-being. As Zerubavel and Wright (2012) suggest, we must "differentiate between disclosures of woundedness and need for intervention or requests for help" (p. 489). If an individual comes to you in search of support or assistance, we encourage you to connect the person to relevant resources, such as campus or local counseling services, human resources, and employee assistance programs.

There may be limited circumstances in which it is appropriate, and perhaps necessary, to ask for more information about a person's lived experience of NSSI than they wish to share or to disclose information about their lived experience to someone else. For instance, a person's ongoing difficulties with NSSI may cause professional impairment, or an individual may be unable or unwilling to see urgently needed psychiatric or medical care. In these circumstances, it is important that you seek consultation and supervision regarding any decision that may infringe on a person's right to privacy or autonomy. We strongly recommend transparency toward the person with lived experience of NSSI regarding planned disclosures of personal information to others (e.g., supervisors). This is consistent with the ethical principle of respect for the dignity of persons, as it applies to both clients and colleagues (APA, 2017).

### **Recommendation 5: Model Openness to Inclusion of People With Lived Experience of NSSI**

One way to convey an openness to lived experience is to intentionally talk about the role of lived experience (whether personal or others') as it contributes to one's work in clinical, research, or teaching domains. As a clinician or supervisor, discuss lived experience and self-disclosure as part of clinical training, consistent with one's theoretical orientation. For example, as part of student training at the second author's institute, the clinical psychology program held a panel and open dialogue comprising students and faculty to address the role of disclosure and lived experience in clinical work, research, and supervision. In research activities, include individuals with lived experience in the research design, study implementation, and interpretation of

the data (Banfield et al., 2018; CIHR, 2018; Lewis & Hasking, 2019). In teaching, include readings by people with lived experience who have successfully navigated their difficulties (Corrigan et al., 2017), particularly in courses that can otherwise pathologize individuals with mental illness (e.g., abnormal psychology).

In all settings, avoid language that distinguishes people with lived experience of mental illness from those who work in the field, as this may further the erroneous assumption that mental health professionals cannot (or should not) have such experiences. Consider being open about personal lived experiences of concealable or stigmatized identities (e.g., sexual orientation and disability), if this is consistent with one's priorities and values.

At an organizational or structural level, there are a variety of programs, policies, advocacy efforts, and systemic changes that could improve inclusion of individuals with lived experience of mental health concerns, including NSSI, in the field of clinical psychology. Many of the recommendations in this arena could be drawn from efforts made on behalf of other underrepresented groups, such as racial and ethnic minorities, that could be broadened to improve inclusion in other domains. These include, for instance, the use of allyship or "safe zone" programs (c.f., Human Rights Campaign, 2019), the establishment of aspirational statements regarding diversity, equity, and inclusion in psychology training programs (Council of Counseling Psychology Training Programs, 2006), and active efforts to recruit and retain individuals from diverse backgrounds into psychology (c.f., Bridge Psychology Network, 2020). Further research is needed to determine whether and how specific programs or policy changes impact subsequent inclusion of people with lived experience of NSSI in the field of psychology. For a summary of our recommendations, see Figure 1.

### **The Decision to Disclose Lived Experience of NSSI**

There are elements of risk in disclosing lived experience of any mental health concern in a professional setting, particularly with a stigmatized behavior such as NSSI. In a study of Veteran Health Administration employees with lived experience of mental illness, many (44%) believed their lived experience was helpful in their job; however, a similar percentage (36%) noted caution about disclosing due to negative repercussions (Boyd, Zeiss, et al., 2016). We recommend thoughtful consideration how positive *and* negative consequences of disclosure align with one's values and personal goals, acknowledging that the decision to disclose may vary based on context (e.g., selective disclosure; Corrigan, 2005). For instance, in the prior study, approximately two-thirds of participants had at least one colleague that knew about their lived experience, but only a third had ever disclosed to clients (Boyd, Zeiss, et al., 2016).

There is empirical evidence of some positive consequences of disclosure, such as reduced self-stigma, dispelling myths about those with lived experience, improved relevance of one's research in related areas, increased potential to build credibility with clients, serving as a positive role model, and living in alignment with one's values (Cain, 2000; Corrigan et al., 2013; Zerubavel & Wright, 2012). At the same time, disclosure can be met with judgment, rejection, concerns about impairment, discrimination, and devaluing of one's accomplishments by peers (Boyd, Zeiss, et al., 2016; Harris et al., 2016). Disclosure of more stigmatized types of lived experience is more likely to prompt negative judgment, questions of one's competence, and even overt hostility (Zerubavel & Wright, 2012).

**Figure 2***Recommendations to Facilitate Decision-Making Regarding Disclosure of Lived Experience of NSSI***1. Determine Desired Outcomes**

- Identify desired outcomes and goals following disclosure.
- Consider the likelihood and/or feasibility of desired outcomes.
- Consider whether intended disclosure recipient is able and/or willing to support goals.
- Investigate whether disclosure could negative impact other goals or priorities.
- Note: Consistent with ethical guidelines, disclosure of lived experience in clinical settings should only occur 1) if disclosure is in the best interest(s) of the client and 2) following consultation with a supervisor or colleague (Bloomgarden & Mennuti, 2009).

**2. Consider the Logistics Carefully**

- Who: specific individual who is likely to be empathetic, supportive, and understanding.
- What: content of the disclosure.
- Where: context of disclosure, ideally private (e.g., closed office).
- When: timing of disclosure, ideally when neither party is rushed.
- How: format of disclosure (written, face-to-face), level of accessibility (disclosure to a single individual or in a publicly available format, such as online text or video)

**3. Anticipate a Range of Responses**

- Consider likely follow-up questions and preferred responses
- Clarify preferences with regard to further disclosures to others
- Be prepared to discuss concerns regarding professional and personal functioning.
- Identify and prepare for “worst case” scenarios, such as disrespectful, stigmatizing, or angry responses from others.
- Consider how to respond if disclosure prompts discriminatory or retaliatory behavior, such as contacting one’s program director, university ombudsperson, or human resources department.

**4. Seek or Maintain Support and Self-Care**

- Seek guidance or mentorship from others who have disclosed lived experience of NSSI, or, if not available, other concealable stigmatized identities.
- Identify sources of social support within and outside the domain in which disclosure has occurred (e.g., graduate program, clinical setting, academic department, company).
- If disclosure has a significant negative impact on personal or professional domains, it may be beneficial to seek support through individual or other types of therapy.

In spite of these concerns, there is a thriving movement within the field of suicidology, and elsewhere, to embrace and welcome individuals with lived experience (American Association of Suicidology, 2019). Although individual suicide attempt survivors have been sharing their stories and experiences for decades, this movement saw increased momentum following the publication of “The way forward: Pathways to hope, recovery, and wellness with insights from lived experience” by the National Action Alliance for Suicide Prevention’s Suicide Attempt Survivors Task Force (2014). This work, and resulting activism and movement within suicidology, may signal a cultural shift contributing to more accepting attitudes toward those with lived experience of NSSI, but to date, research has not been conducted to support or refute this idea. Decisions to self-disclose are complicated and should not be taken lightly, as they deserve mindful reflection prior to disclosure (Chaudoir & Fisher 2010; Corrigan et al., 2013). Ultimately, it is essential to

balance perceived benefits to an individual and/or the profession alongside the very real potential for negative consequences associated with disclosure. We recommend considering a variety of factors to determine whether, when, and how to disclose lived experience with NSSI; we present these recommendations, which were developed on the basis of personal and professional experience and expertise, in Figure 2. For a broader discussion of the costs and benefits related to the decision to disclose lived experience of mental illness, see Corrigan (2005).

**Conclusions**

Given the increasing incidence of NSSI, the prevalence of lived experience of mental illness among psychologists broadly, and the significant stigma associated with these experiences, it is essential that individuals, employers, and advocacy organizations work together to

facilitate inclusion of people with lived experience of NSSI and other mental health concerns in the field of clinical psychology. This will assuredly require further research that examines the extent and nature of lived experience of NSSI in the field, and to test the effectiveness of specific proposals for ameliorating biases and related obstacles to inclusion. The above recommendations are intended to improve the well-being and professional success of people with lived experience of NSSI, but these endeavors are not solely, or even primarily, about benefits for individuals. Rather, we believe that, by making explicit efforts to address the numerous barriers to inclusion described above, we can build a more diverse and inclusive profession, which will, in turn, contribute to improvements in clinical training and care, research endeavors, and public education and advocacy efforts by psychologists with and without lived experience of NSSI.

## References

- American Association of Suicidology. (2019). *Suicide attempt survivors*. Retrieved May 1, 2019 <https://www.suicidology.org/suicide-survivors/suicide-attempt-survivors>
- American Psychological Association. (2017). *Ethical principles of psychologists and codes of conduct*. Retrieved April 19, 2019 <https://www.apa.org/ethics/code/index>
- Appleby, D. C., & Appleby, K. M. (2006). Kisses of death in the graduate school application process. *Teaching of Psychology, 33*(1), 19–24. [https://doi.org/10.1207/s15328023top3301\\_5](https://doi.org/10.1207/s15328023top3301_5)
- Baker, K. J. M. (2014, February 11). How colleges flunk mental health. *Newsweek Magazine*. <https://www.newsweek.com/2014/02/14/how-colleges-flunk-mental-health-245492.html>
- Banfield, M., Randall, R., O'Brien, M., Hope, S., Gulliver, A., Forbes, O., Morse, A. R., Griffiths, K. (2018). Lived experience researchers partnering with consumers and carers to improve mental health research: Reflections from an Australian initiative. *International Journal of Mental Health Nursing, 27*, 1219–1229. <https://doi.org/10.1111/inm.12482>
- Bentley, K. H., Cassiello-Robbins, C. F., Vittorio, L., Sauer-Zavala, S., & Barlow, D. H. (2015). The association between nonsuicidal self-injury and the emotional disorders: A meta-analytic review. *Clinical Psychology Review, 37*, 72–88. <https://doi.org/10.1016/j.cpr.2015.02.006>
- Bos, A. E., Kanner, D., Muris, P., Janssen, B., & Mayer, B. (2009). Mental illness stigma and disclosure: Consequences of coming out of the closet. *Issues in Mental Health Nursing, 30*, 509–513. <https://doi.org/10.1080/01612840802601382>
- Boyd, J. E., Graunke, B., Frese, F. J., Jones, J. T. R., Adkins, J. W., & Bassman, R. (2016). State psychology licensure questions about mental illness and compliance with the Americans with Disabilities Act. *American Journal of Orthopsychiatry, 86*(6), 620–631. <https://doi.org/10.1037/ort0000177>
- Boyd, J. E., Zeiss, A., Reddy, S., & Skinner, S. (2016). Accomplishments of 77 VA mental health professionals with a lived experience of mental illness. *American Journal of Orthopsychiatry, 86*(6), 610–619. <https://doi.org/10.1037/ort0000208>
- Bridge Psychology Network. (2020). *Building Roads to Inclusion and Diversity in Graduate Education (BRIDGE) Clinical Psychology Network*. Retrieved April 11, 2020 <http://www.bridgepsychology.org/>
- Cain, N. R. (2000). Psychotherapists with personal histories of psychiatric hospitalization countertransference in wounded healers. *Psychiatric Rehabilitation Journal, 24*(1), 22–28. <https://doi.org/10.1037/h0095127>
- Canadian Institutes of Health Research. (2018). *About SPOR*. Retrieved April 22, 2019 <http://www.cihr-irsc.gc.ca/e/51036.html>
- Carey, B. (2011, June 23). Expert on mental illness reveals her own fight. *The New York Times*, A1.
- Cepedo-Benito, A., & Short, P. (1998). Self-concealment, avoidance of psychological services, and perceived likelihood of seeking professional help. *Journal of Counseling Psychology, 45*, 58–64. <https://doi.org/10.1037/0022-0167.45.1.58>
- Chadoir, S. R., & Fisher, J. D. (2010). The disclosure process model: Understanding disclosure decision making and postdisclosure outcomes among people living with a concealable stigmatized identity. *Psychological Bulletin, 136*(2), 236–256. <https://doi.org/10.1037/a0018193>
- Corrigan, P. W. (2005). Dealing with stigma through personal disclosure. In P. W. Corrigan (Ed.), *On the stigma of mental illness: Practical strategies for research and social change* (pp. 257–280). American Psychological Association. <https://doi.org/10.1037/10887-012>
- Corrigan, P. W., Kosyluk, K. A., & Rüsck, N. (2013). Reducing self-stigma by coming out proud. *American Journal of Public Health, 103*(5), 794–800. <https://doi.org/10.2105/AJPH.2012.301037>
- Corrigan, P. W., Niewegowski, K., Buchholz, B. A., & Al-Khouja, M. A. (2017). *Honest, open, proud to eliminate the stigma of mental illness manual*. Retrieved April 2, 2019 [www.hopprogram.org](http://www.hopprogram.org)
- Council of Counseling Psychology Training Programs. (2006). *Counseling psychology model training values statement addressing diversity*. Retrieved April 11, 2020 <https://www.cccptp.org/ccptp-model-training-values-statement-addressing-diversity>
- Culbreth, J. R. (2000). Substance abuse counselors with and without a personal history of chemical dependency: A review of the literature. *Alcoholism Treatment Quarterly, 18*, 67–82. [https://doi.org/10.1300/J020v18n02\\_05](https://doi.org/10.1300/J020v18n02_05)
- Gelso, C. J., & Hayes, J. A. (2007). *Countertransference and the therapist's inner experience: Perils and possibilities*. Lawrence Erlbaum. <https://doi.org/10.4324/9780203936979>
- Gibb, S. J., Beautrais, A. L., & Surgenor, L. J. (2010). Health-care staff attitudes towards self-harm patients. *Australian and New Zealand Journal of Psychiatry, 44*, 713–720. <https://doi.org/10.3109/00048671003671015>
- Gilroy, P. J., Carroll, L., & Murra, J. (2002). A preliminary survey of counseling psychologists' personal experiences with depression and treatment. *Professional Psychology: Research and Practice, 33*(4), 402–407. <https://doi.org/10.1037/0735-7028.33.4.402>
- Gray, L. A., Ladany, N., Walker, J. A., & Ancis, J. R. (2001). Psychotherapy trainees' experience of counterproductive events in supervision. *Journal of Counseling Psychology, 48*(4), 371–383. <https://doi.org/10.1037/0022-0167.48.4.371>
- Grollman, E. A. (2014). *Objectivity doesn't exist (and that's a good thing)*. Retrieved April 15, 2019 <https://conditionallyaccepted.com/2014/04/10/objectivity/>
- Harris, J. I., Leskela, J., & Hoffman-Konn, L. (2016). Provider lived experience and stigma. *American Journal of Orthopsychiatry, 86*(6), 604–609. <https://doi.org/10.1037/ort0000179>
- Hartocollis, A. (2018, August 31). They sought help on campus, but were sent home instead. *The New York Times*, A11.
- Hasking, P., & Boyes, M. (2018). A commentary on language and stigma in the context of nonsuicidal self-injury. *Journal of Nervous and Mental Disease, 206*(11), 829–833. <https://doi.org/10.1097/NMD.0000000000000899>
- Human Rights Campaign. (2019). *Establishing an allies/safe zone program*. Retrieved May 6, 2019 <https://www.hrc.org/resources/establishing-an-allies-safe-zone-program>
- Huprich, S. K., & Rudd, M. D. (2004). A national survey of trainee impairment in clinical, counseling, and school psychology doctoral programs and internships. *Journal of Clinical Psychology, 60*(1), 43–52. <https://doi.org/10.1002/jclp.10233>
- International Society for the Study of Self-Injury. (2018). *What is nonsuicidal self-injury?* Retrieved July 1, 2018 <https://itriples.org/category/about-self-injury>
- Irvin-Mitchell, A. (2017, September 5). *Students can face disciplinary action for self-injury at Chatham University. Three students share their stories*.

- Public Source, Retrieved April 2, 2019 <https://www.publicsource.org/students-can-face-disciplinary-action-for-self-injury-at-chatham-university-three-students-share-their-stories/>
- Jones, N., Harrison, J., Aguiar, R., & Munro, L. (2014). Transforming research for transformative change in mental health: towards the future. In G. Nelson, B. Kloos, & J. Ornelas (Eds.), *Community psychology and community mental health: Towards transformative change*. Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780199362424.003.0017>
- Klonsky, E. D., Muehlenkamp, J. J., Lewis, S. P., & Walsh, B. (2011). *Nonsuicidal self-injury*. Hogrefe.
- Lewis, S. P. (2016a). The overlooked role of self-injury scars: Commentary and suggestions for clinical practice. *Journal of Nervous and Mental Disease*, 204(1), 33–35. <https://doi.org/10.1097/NMD.0000000000000436>
- Lewis, S. P. (2016b). Cutting through the shame. *Canadian Medical Association Journal*, 188(17–18), 1265–1266. <https://doi.org/10.1503/cmaj.160119>
- Lewis, S. P., & Hasking, P. (2019). Putting the “self” in self-injury research: Inclusion of people with lived experience in the research process. *Psychiatric Services*, 70, 1058–1060. <https://doi.org/10.1176/appi.ps.201800488>
- Lewis, S. P., & Mehrabkhani, S. (2016). Every scar tells a story: Insight into people’s self-injury scar experiences. *Counselling Psychology Quarterly*, 29(3), 296–310. <https://doi.org/10.1080/09515070.2015.1088431>
- Lewis, S. P., Mahdy J. C., Michal N. J., & Arbutnott, A. E. (2014). Googling self-injury: The state of health information obtained through online searches for self-injury. *JAMA Pediatrics*, 168(5), 443–449. <https://doi.org/10.1001/jamapediatrics.2014.187>
- Lloyd, B., Blazely, A., & Phillips, L. (2018). Stigma towards individuals who self harm: Impact of gender and disclosure. *Journal of Public Mental Health*, 17(4), 184–194. <https://doi.org/10.1108/JPMH-02-2018-0016>
- McAllister, M., Creedy, D., Moyle, W., & Farrugia, C. (2002). Nurses’ attitudes towards clients who self-harm. *Journal of Advanced Nursing*, 40(5), 578–586. <https://doi.org/10.1046/j.1365-2648.2002.02412.x>
- National Action Alliance for Suicide Prevention. Suicide Attempt Survivors Task Force. (2014). *The way forward: Pathways to hope, recovery, and wellness with insights from lived experience*. Retrieved April 22, 2019 <https://theactionalliance.org/sites/default/files/the-way-forward-final-2014-07-01.pdf>
- Norcross, J. C., Sayette, M. A., & Pomerantz, A. M. (2018). Doctoral training in clinical psychology across 23 years: Continuity and change. *Journal of Clinical Psychology*, 74(3), 385–397. <https://doi.org/10.1002/jclp.22517>
- Pachankis, J. E. (2007). The psychological implications of concealing a stigma: A cognitive-affective-behavioral model. *Psychological Bulletin*, 133, 328–345. <https://doi.org/10.1037/0033-2909.133.2.328>
- Pope, K. S., & Tabachnick, B. (1994). Therapists as patients: A national survey of psychologists’ experiences, problems, and beliefs. *Professional Psychology: Research and Practice*, 25(3), 247–258. <https://doi.org/10.1037/0735-7028.25.3.247>
- Reavley, N. J., Morgan, A. J., & Jorm, A. F. (2018). Disclosure of mental health problems: Findings from an Australian national survey. *Epidemiology and Psychiatric Sciences*, 27(4), 346–356. <https://doi.org/10.1017/S204579601600113X>
- Rosenrot, S. A., & Lewis, S. P. (2020). Barriers and responses to the disclosure of non-suicidal self-injury: A thematic analysis. *Counselling Psychology Quarterly*, 33(2), 121–141. <https://doi.org/10.1080/09515070.2018.1489220>
- Sherman, M. D. (1996). Distress and professional impairment due to mental health problems among psychotherapists. *Clinical Psychology Review*, 16(4), 299–315. [https://doi.org/10.1016/0272-7358\(96\)00016-5](https://doi.org/10.1016/0272-7358(96)00016-5)
- Smith, P. L., & Moss, S. B. (2009). Psychologist impairment: What is it, how can it be prevented, and what can be done to address it? *Clinical Psychology: Science and Practice*, 16(1), 1–15. <https://doi.org/10.1111/j.1468-2850.2009.01137.x>
- Sue, D. W., Sue, D., Neville, H. A., & Smith, L. (2019). *Counseling the culturally diverse: Theory and practice* (8th ed.). Wiley.
- Sumerau, J. (2015). *What is me-search?* Retrieved April 2, 2019 <http://writewhereithurts.net/2015/06/18/what-is-me-search/>
- Talley, A. E., & Littlefield, A. K. (2014). Pathways between concealable stigmatized identities and substance misuse: Pathways between concealable stigmatized. *Social and Personality Psychology Compass*, 8(10), 569–582. <https://doi.org/10.1111/spc3.12117>
- Walsh, B. W. (2012). *Treating self-injury: A practical guide* (2nd ed.). Guilford Press.
- Wester, K., Trepal, H., & King, K. (2018). Nonsuicidal self-injury: Increased prevalence in engagement. *Suicide & Life-Threatening Behavior*, 48(6), 690–698. <https://doi.org/10.1111/sltb.12389>
- White, W. L. (2000). The role of recovering physicians in 19th century addiction medicine: An organizational case study. *Journal of Addictive Diseases*, 19(2), 1–10. [https://doi.org/10.1300/J069v19n02\\_01](https://doi.org/10.1300/J069v19n02_01)
- Williams, R. (2014, January 24). *We just can’t have you here*. Yale Daily News, Retrieved April 2, 2019 <https://yaledailynews.com/blog/2014/01/24/we-just-cant-have-you-here/>
- Zerubavel, N., & Wright, M. O. (2012). The dilemma of the wounded healer. *Psychotherapy: Theory, Research, & Practice*, 4(4), 482–491. <https://doi.org/10.1037/a0027824>

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